WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
	Elkins	**Jason**		**256590952**	**01/06/2019**

A. IDENTIFYING INFORMATION

EMPLOYEE	X Male / Female	Birthdate **01/18/1973**	Phone Number **(478) 279-6864**	Employee E-mail	
Address **4938 Old Highway 1,**		City **Wadley**	State **GA**	Zip Code **30477**	
EMPLOYER	Name **GMA- BARTOW**	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)		
Address **PO Box 248, Bartow, GA 30413**		Phone Number **(478) 364-3300**	Employer FEIN **581390659**		
		Employer E-mail			
INSURER / SELF-INSURER	Name **Georgia Municipal Association**	Insurer/ Self-Insurer FEIN **58-1740980**	Insurer/ Self-Insurer File # **0765-WC-19-0000064**		
CLAIMS OFFICE	Name **CORVEL CORP**	Claims Office FEIN #	Claims Office Phone **(678) 942-7300**	Claims Office E-mail	
SBWC ID # (five digit no.)	Address **P.O. Box 898**	City **Duluth**	State **GA**	Zip Code **30096**	

EMPLOYMENT/WAGE Insurer Type Code	Date Hired by Employer **01/01/2001**	Job Classified Code No.	Number of Days Worked Per Week **0**	Wage rate at time of Injury or Disease: **0.00**	per Hour / per Day / per Week / per Month
Insurer / Self-Insurer / Group Fund	List Normally Scheduled Days Off				
INJURY/ILLNESS & MEDICAL	Time of Injury **9:30 PM**	County of Injury	Date Employer Notified **01/15/2019**	Enter First Date Employee Failed to Work a Full Day	
Did Employee Receive Full Pay on Date of Injury?	Did Injury/Illness Occur on Employer's Premises?	Type of Injury/Illness **Multiple Physical Injuries Only**	Body Part Affected **Body Systems and Multiple Body**		
How Injury or Illness / Abnormal Health Condition Occurred	**IW was working the scene of a train derailment and was exposed to chemical fumes from hydrochloric acid and hydrogen peroxide mixing together and forming a chemical cloud. IW sought treatment on 01/08/2019 for**				

Treating Physician (Name and Address)	Initial Treatment Given	Hospital / Treating Facility (Name and Address)		
,	None	**Jefferson Hospital , Louisville, GA**	If Returned to Work, Give Date	**01/06/2019**
	Minor: By Employer		Returned to what wage Per Week	**0.00**
	Minor Clinic/Hospital		If Fatal, Enter Complete Date of Death	
	X Emergency Room			
	Hospitalized > 24 hours			

Report Prepared By (Print or Type)	Telephone Number	Date of Report
Robert Morris	**(706) 214-0696**	**01/17/2019**

B. INCOME BENEFITS

Previously Medical Only	Average Weekly Wage: $ **0.00**		Weekly benefit: $ **0.00**	Date of disability:	
Date of first Payment		Compensation paid: $ **0.00**	Or Date salary paid:	Penalty paid: $ **0.00**	
BENEFITS ARE PAYABLE FROM		FOR:			

☐ Total/ temporary total disability ☐ Temporary partial ☐ Permanent partial disability of **0** % to _____ for **0** weeks.
UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY INJURY

No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filling Form)	Signature	Date
Robert Morris		**01/17/2019**
Phone and Ext. **(706) 214-0696**	E-mail **townbartow@outlook.com**	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. 34-9-18 AND 34-9-19).